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Medical Records Request

I, _____ , DOB _____, SS #_____,
(PATIENT NAME)

HEREBY AUTHORIZE THIS OFFICE TO:

REQUEST COPIES OF MY MEDICAL RECORDS ***RELEASE COPIES OF MY MEDICAL RECORDS***

FROM: _____ ***TO:*** _____

_____ _____

_____ _____

For the specific purposes I have checked below:

( ) Continued Medical Care
( ) Changing Primary Care Physicians and discontinuing care at this office
( ) Leaving town and transferring records to new physician
( ) Personal reasons: _____
( ) School / Immunization: _____
( ) Attorney
( ) Insurance
( ) Office of Disability Insurance
( ) Workers' Compensation

In addition to the foregoing, I authorize the release of the following records (initial if appropriate):

_____ Drug and alcohol abuse records.

_____ Psychiatric or psychotherapeutic records.

_____ Sexually transmissible disease and HIV test results.

I release and hold harmless Wilson Family Medicine, LLC, members and employees, for all liability, including for negligence, that may arise from complying with this authorization.

PROHIBITION ON REDISCLOSURE BY REQUESTOR:

This information is being disclosed from records whose confidentiality is protected. No further disclosure can be made without my specifically written consent. A general authorization is not sufficient for this purpose.

AUTHORIZATION:

I ACKNOWLEDGE THAT I HAVE READ THIS AUTHORIZATION AND FULLY UNDERSTAND ITS CONTENTS. THIS AUTHORIZATION IS VALID FOR ONE YEAR AFTER THE DATE OF EXECUTION.

_____
Patient or Legal Guardian's Signature Date Signed

_____
Processed By Date